Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

FOREST PARK MEDICAL CENTER
11990 N CENTRAL EXPRESSWAY
DALLAS TX 75243

Respondent Name

POLY AMERICA LP

MFDR Tracking Number

M4-10-4838

Carrier's Austin Representative Box

Box Number 11

MFDR Date Received

July 23, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Working compensation claim was denied by reviewer before claim was submitted. Please review the additional documentation submitted…"

Amount in Dispute: $288,760.55

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "A CCH decision was rendered on 9/9/08 ruling that the compensable injury did NOT include Spondylolisthesis at L5-S1 and Foraminal Stenosis at L5-S1. While the compensable injury includes findings of disc bulge at L4-5 and disc bulge with annular tear at L5-S1, the medical documentation clearly shows that the claimant's 'condition' is a result of spondylolisthesis at L5-S1 and foraminal stenosis at L5-S1. On 8/4/09, a review of the medical indicated the claimant's condition was due to spondylolisthesis and foraminal stenosis at L5-S1. The surgeon was advised that these were non-compensable under the claimant's workers compensation claim and would not be covered. The surgeon proceeded with the surgery and the surgical report confirms the claimant's diagnosis was Spondylosis, Spondylolisthesis and Foraminal Stenosis at L5-S1. Conditions not compensable under claimant's workers compensation claim. The Respondent/Carrier contends that the submitted bills were processed correctly and were denied in accordance with the decision rendered on 9/9/08 by the TDIDWC hearing officer. The Respondent/Carrier should not be responsible for any additional payment on the bills in question."

Response Submitted by: Avizent for Poly America LP, P. O. Box 803355, Dallas, TX 75380

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 26, 2009 Through August 31, 2009	Inpatient Hospital Surgical Services	$288,760.55	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 and §133.307, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, sets out the procedures for resolving medical fee disputes.

Issues

1. Have the relevant extent of injury issues been resolved?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §133.305(a)(4) defines a medical fee dispute as a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) that has been determined to be medically necessary and appropriate for treatment of that employee's compensable injury. 28 Texas Administrative Code §133.305(b) requires that "if a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021." The services in dispute were denied, in part, due to unresolved extent of injury issues. The issues raised and relevant to the services in this medical fee dispute involved whether the compensable injury extended to spondylolisthesis at L5-S1, and foraminal stenosis at L5-S1. A contested case hearing was held and a decision was issued on September 4, 2008. In its decision, the division concluded that the compensable injury of August 26, 2006 **did not include** spondylolisthesis at L5-S1, nor did it include foraminal stenosis at L5-S1. The division finds that the relevant issues were resolved.
2. Review of the submitted operative report indicates that spondylolisthesis at L5-S1 was treated. Specifically, the operative report states, "preoperative diagnoses: 1. Spondylolysis, L5-S1; 2. Spondylolisthesis, L5-S1; and 3. Foraminal stenosis, L5-S1 with bilateral lower extremity radiculopathy…postoperative diagnoses: 1. Spondylolysis, L5-S1; 2. Spondylolisthesis, L5-S1; and 3. Foraminal stenosis, L5-S1…" The division concludes that the services in dispute were rendered by the requestor to treat an injury found to be non-compensable according to the Contested Case Hearing decision discussed above. For that reason, no reimbursement can be recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		December 06, 2012
Signature	Medical Fee Dispute Resolution Officer	Date
		December 06, 2012
Signature	Deputy Commissioner, Health Care Management	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.